SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
Company Tracking Number:	*CMMUCTOC09/10AR*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement Outline 09/10*		
Project Name/Number:	*UCT/CMMUCTOC09/10AR*		

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Medicare Supplement Outline 09/10	SERFF Tr Num: WAKE-126488368	State: Arkansas
TOI: MS06 Medicare Supplement - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 44836
Sub-TOI: MS06.000 Medicare Supplement - Other	Co Tr Num: CMMUCTOC09/10AR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Toni Hess, Katlyn Gorman, Steve Keck, Chris Moser	Disposition Date: 03/17/2010
	Date Submitted: 02/12/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: UCT	Status of Filing in Domicile: Not Filed
Project Number: CMMUCTOC09/10AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Not Required
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 03/17/2010	Explanation for Other Group Market Type:
	State Status Changed: 03/17/2010
Deemer Date:	Created By: Chris Moser
Submitted By: Chris Moser	Corresponding Filing Tracking Number:

Filing Description:

RE: The Order of United Commercial Travelers of America

NAIC Number: 56383

FEIN Number: 31-4273120

SUBMISSION

SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
Company Tracking Number:	*CMMUCTOC09/10AR*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement Outline 09/10*		
Project Name/Number:	*UCT/CMMUCTOC09/10AR*		

Medicare Supplement – Outline of Coverage – Form Number: MSI OC 10 AR

Wakely Actuarial Services, Inc. has been retained by The Order of United Commercial Travelers of America to file the above-captioned form on their behalf. We are requesting the review and approval of these forms. A letter of authorization is included for reference.

All required filing documents have been completed and are included with the filing.

The filing of this Medicare Supplement Outline of Coverage represents the annual filing of this outline as required by your state. This outline will be used with the Medicare Supplement Plans A, B, E, and F approved on 9/2/05 and Plan G approved on 6/6/06 and reflect the 2010 Medicare Deductibles/Coinsurance amounts and the applicable rates. Wakely Actuarial Services, Inc. appreciates the Department's time and consideration with this filing.

Company and Contact

Filing Contact Information

Christopher Moser, Compliance Analyst
931 Clarmont Avenue
Bensalem, PA 19020

Chris.M.Moser@hesscc.com
215-500-4269 [Phone]

Filing Company Information

(This filing was made by a third party - WAS01)

The Order of United Commercial Travelers of America	CoCode: 56383	State of Domicile: Ohio
1801 Watermark Drive, Suite 100	Group Code: -99	Company Type:
P.O. Box 159019	Group Name:	State ID Number:
COLUMBUS, OH 43215-8619	FEIN Number: 31-4273120	
(800) 848-0123 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	1 Form - $50.00

SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
Company Tracking Number:	*CMMUCTOC09/10AR*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement Outline 09/10*		
Project Name/Number:	*UCT/CMMUCTOC09/10AR*		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	$50.00	02/12/2010	34159910

SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
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Project Name/Number:	*UCT/CMMUCTOC09/10AR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	03/17/2010	03/17/2010

SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
Company Tracking Number:	*CMMUCTOC09/10AR*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement Outline 09/10*		
Project Name/Number:	*UCT/CMMUCTOC09/10AR*		

Disposition

Disposition Date: 03/17/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
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Project Name/Number:	*UCT/CMMUCTOC09/10AR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Medicare Supplement Outline of Coverage	Approved	Yes

SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
Company Tracking Number:	*CMMUCTOC09/10AR*		
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Product Name:	*Medicare Supplement Outline 09/10*		
Project Name/Number:	*UCT/CMMUCTOC09/10AR*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/17/2010	MSI OC 10 AR	Outline of Coverage	Medicare Supplement Outline of Coverage	Initial		46.900	MSI OC 10 AR.pdf

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Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, B, E, F and G

These charts show the benefits included in each Medicare supplement plans.
Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $2,000 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign emergency deductible.

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Outline of Medicare Supplement Coverage – Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	$4,620 Out of Pocket Annual Limit ***	$2,310 Out of Policy Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plans pays 100% of the Medicare copayments, coinsurances, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

***** The out-of-pocket annual limit will increase each year for inflation.**

See Outlines of Coverage for details and exceptions.

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Annual Premium Rates for use in Arkansas

All Ages	Plan A		Plan B		Plan E		Plan F		Plan G	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Non-Smoker Rates for Zip Code 722	$2,035.83	$2,035.83	$3,116.09	$3,116.09	$2,155.93	$2,155.93	$2,491.78	$2,491.78	$2,205.12	$2,205.12
Smoker Rates for Zip Code 722	$2,035.83	$2,035.83	$3,116.09	$3,116.09	$2,695.33	$2,695.33	$3,116.00	$3,116.00	$2,753.01	$2,753.01
Non-Smoker Rates for Zip Codes 720, 721	$2,035.83	$2,035.83	$3,116.09	$3,116.09	$1,940.34	$1,940.34	$2,242.60	$2,242.60	$1,984.61	$1,984.61
Smoker Rates for Zip Codes 720, 721	$2,035.83	$2,035.83	$3,116.09	$3,116.09	$2,425.80	$2,425.80	$2,804.40	$2,804.40	$2,477.71	$2,477.71
Non-Smoker Rates for All Zip Codes Except 720-722	$2,035.83	$2,035.83	$3,116.09	$3,116.09	$1,832.54	$1,832.54	$2,118.01	$2,118.01	$1,874.35	$1,874.35
Smoker Rates for All Zip Codes Except 720-722	$2,035.83	$2,035.83	$3,116.09	$3,116.09	$2,291.03	$2,291.03	$2,648.60	$2,648.60	$2,340.06	$2,340.06

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Semi-Annual Premium Rates for use in Arkansas

All Ages	Plan A		Plan B		Plan E		Plan F		Plan G	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Non-Smoker Rates for Zip Code 722	$1,048.45	$1,048.45	$1,604.79	$1,604.79	$1,110.30	$1,110.30	$1,283.27	$1,283.27	$1,135.64	$1,135.64
Smoker Rates for Zip Code 722	$1,048.45	$1,048.45	$1,604.79	$1,604.79	$1,388.09	$1,388.09	$1,604.74	$1,604.74	$1,417.80	$1,417.80
Non-Smoker Rates for Zip Codes 720, 721	$1,048.45	$1,048.45	$1,604.79	$1,604.79	$999.27	$999.27	$1,154.94	$1,154.94	$1,022.07	$1,022.07
Smoker Rates for Zip Codes 720, 721	$1,048.45	$1,048.45	$1,604.79	$1,604.79	$1,249.29	$1,249.29	$1,444.27	$1,444.27	$1,276.02	$1,276.02
Non-Smoker Rates for All Zip Codes Except 720-722	$1,048.45	$1,048.45	$1,604.79	$1,604.79	$943.76	$943.76	$1,090.78	$1,090.78	$965.29	$965.29
Smoker Rates for All Zip Codes Except 720-722	$1,048.45	$1,048.45	$1,604.79	$1,604.79	$1,179.88	$1,179.88	$1,364.03	$1,364.03	$1,205.13	$1,205.13

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Quarterly Premium Rates for use in Arkansas

All Ages	Plan A		Plan B		Plan E		Plan F		Plan G	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Non-Smoker Rates for Zip Code 722	$534.41	$534.41	$817.97	$817.97	$565.93	$565.93	$654.09	$654.09	$578.84	$578.84
Smoker Rates for Zip Code 722	$534.41	$534.41	$817.97	$817.97	$707.52	$707.52	$817.95	$817.95	$722.67	$722.67
Non-Smoker Rates for Zip Codes 720, 721	$534.41	$534.41	$817.97	$817.97	$509.34	$509.34	$588.68	$588.68	$520.96	$520.96
Smoker Rates for Zip Codes 720, 721	$534.41	$534.41	$817.97	$817.97	$636.77	$636.77	$736.16	$736.16	$650.40	$650.40
Non-Smoker Rates for All Zip Codes Except 720-722	$534.41	$534.41	$817.97	$817.97	$481.04	$481.04	$555.98	$555.98	$492.02	$492.02
Smoker Rates for All Zip Codes Except 720-722	$534.41	$534.41	$817.97	$817.97	$601.40	$601.40	$695.26	$695.26	$614.27	$614.27

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EFT Monthly Premium Rates for use in Arkansas

All Ages	Plan A		Plan B		Plan E		Plan F		Plan G	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Non-Smoker Rates for Zip Code 722	$169.65	$169.65	$259.66	$259.66	$179.65	$179.65	$207.64	$207.64	$183.75	$183.75
Smoker Rates for Zip Code 722	$169.65	$169.65	$259.66	$259.66	$224.60	$224.60	$259.66	$259.66	$229.41	$229.41
Non-Smoker Rates for Zip Codes 720, 721	$169.65	$169.65	$259.66	$259.66	$161.69	$161.69	$186.88	$186.88	$165.38	$165.38
Smoker Rates for Zip Codes 720, 721	$169.65	$169.65	$259.66	$259.66	$202.14	$202.14	$233.69	$233.69	$206.47	$206.47
Non-Smoker Rates for All Zip Codes Except 720-722	$169.65	$169.65	$259.66	$259.66	$152.71	$152.71	$176.49	$176.49	$156.19	$156.19
Smoker Rates for All Zip Codes Except 720-722	$169.65	$169.65	$259.66	$259.66	$190.91	$190.91	$220.71	$220.71	$195.00	$195.00

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Direct Monthly Premium Rates for use in Arkansas

All Ages	Plan A		Plan B		Plan E		Plan F		Plan G	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Non-Smoker Rates for Zip Code 722	$203.58	$203.58	$311.61	$311.61	$215.59	$215.59	$249.18	$249.18	$220.51	$220.51
Smoker Rates for Zip Code 722	$203.58	$203.58	$311.61	$311.61	$269.53	$269.53	$311.60	$311.60	$275.30	$275.30
Non-Smoker Rates for Zip Codes 720, 721	$203.58	$203.58	$311.61	$311.61	$194.03	$194.03	$224.26	$224.26	$198.46	$198.46
Smoker Rates for Zip Codes 720, 721	$203.58	$203.58	$311.61	$311.61	$242.58	$242.58	$280.44	$280.44	$247.77	$247.77
Non-Smoker Rates for All Zip Codes Except 720-722	$203.58	$203.58	$311.61	$311.61	$183.25	$183.25	$211.80	$211.80	$187.44	$187.44
Smoker Rates for All Zip Codes Except 720-722	$203.58	$203.58	$311.61	$311.61	$229.10	$229.10	$264.86	$264.86	$234.01	$234.01

PREMIUM INFORMATION

We, The Order of United Commercial Travelers of America, can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your issue age.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to the representative through whom the policy was purchased. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do ***NOT*** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither The Order of United Commercial Travelers of America nor its agents are connected with Medicare.

This outline of coverage does not give all of the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,100	$0	$1,100 (Part A Deductible)
61st - 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $155 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,100	$1,100 (Part A Deductible)	$0
61st - 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN B
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $155 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN E
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN E PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,100	$1,100 (Part A Deductible)	$0
61st - 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN E
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $155 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN E PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN E PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN E
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN E PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE** Some annual physical and preventative tests and services administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional Charges	 $0 $0	 $120 $0	 $0 All costs

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,100	$1,100 (Part A Deductible)	$0
61st - 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $155 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $155 of Medicare Approved Amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare Approved Amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $155 of Medicare Approved Amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,100	$1,100 (Part A Deductible)	$0
61st - 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
- Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st - 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $155 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First $155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $155 (Part B Deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD First 3 pints Next $155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $155 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G
MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week.	
- Calendar year maximum	$0	$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

SERFF Tracking Number:	*WAKE-126488368*	*State:*	*Arkansas*
Filing Company:	*The Order of United Commercial Travelers of America*	*State Tracking Number:*	*44836*
Company Tracking Number:	*CMMUCTOC09/10AR*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Medicare Supplement Outline 09/10*		
Project Name/Number:	*UCT/CMMUCTOC09/10AR*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	03/17/2010

Comments:

Attachments:

Read Cert 2-11-10.pdf
CONS NOTE.do.pdf
Arkansas Rule 19.pdf
Arkansas Rule 49.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	Not Applicable Outline of Coverage Filing, The Outline is on the Forms Tab		
Comments:			

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

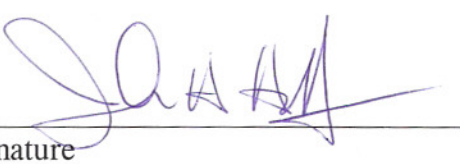
The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
Columbus, Ohio 43215

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Outline of Coverage	MSA OC 10	46.9

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.



Signature

Joseph Hoffman
Name

Chief Executive Officer
Title

Consumer Notice
The Order of United Commercial Travelers of America

Policyholder Service Office:	**1801 Watermark Drive, Suite 100** **Columbus, Ohio 43215-8619**
Telephone Number:	**800-848-0123**
Name of Agent:	**[Fred Smith]**
Agent Address:	**[123 First Street, Any Town, Arkansas]**
Agent Telephone Number:	**[555-555-1234]**

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460

Arkansas
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Outline of Coverage	MSI OC 10 AR

I Hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the State of Insurance.

Signature

Christopher M. Moser
Name

Compliance Analyst
Title

Arkansas
Rule and Regulation 49 Certification

Title of Form(s)	Form Number
Outline of Coverage	MSI OC 10 AR

I Hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Christopher M. Moser
Name

Compliance Analyst
Title